Ustekinumab (STELARA) for Inflammatory Bowel Disease (Crohn’s Disease and Ulcerative Colitis)

Weight: ____________ kg  Height: ____________ cm

Allergies:

Diagnosis Code:

Treatment Start Date: ____________  Patient to follow up with provider on date: ____________

**This plan will expire after 365 days at which time a new order will need to be placed**

GUIDELINES FOR ORDERING
1. Send FACE SHEET and H&P or most recent chart note.
2. A Tuberculin test must have been placed and read as negative prior to initiation of treatment (PPD or QuantiFERON Gold blood test). Please send results with order. If result is indeterminate, a follow up chest X-ray must be performed to rule out TB. Please send results with order. Patients should not have an active ongoing infection at the onset of ustekinumab therapy.
3. Monitor patients for signs / symptoms of active TB, infection, reversible posterior leukoencephalopathy syndrome (RPLS), and malignancy throughout therapy.

PRE-SCREENING: (Results must be available prior to initiation of therapy):
- Tuberculin skin test or QuantiFERON Gold blood test results scanned with orders
- Chest X-Ray result scanned with orders if TB test result is indeterminate.

LABS:
- CBC+DIFF, Routine, ONCE
- COMPLETE METABOLIC PANEL, Routine, ONCE

NURSING ORDERS
1. TREATMENT PARAMETER – Hold treatment and contact provider if TB test result is positive or if screening has not been performed.
2. Follow facility policies and/or protocols for vascular access maintenance with appropriate flush solution, declotting (alteplase), and/or dressing changes.
3. For signs and symptoms of active infection contact provider prior to administering.

MEDICATIONS (select one):

Initial Dose:

ustekinumab (STELARA) in NaCl 0.9 % (NS), administer over 1 hour, low-protein binding filter required

| Less than or equal to 55 kg | 260 mg (two 130 mg vials) |
| Greater than 55-85 kg | 390 mg (three 130 mg vials) |
| Greater than 85 kg | 520 mg (four 130 mg vials) |
Maintenance Doses:
- ○ ustekinumab (STELARA) 90 mg subcutaneous every 8 weeks starting 8 weeks after initial dose.

AS NEEDED MEDICATIONS:
1. acetaminophen (TYLENOL) tablet, 650 mg, oral, EVERY 4 HOURS AS NEEDED for fever
2. diphenhydrAMINE (BENADRYL) capsule, 25 mg, oral, EVERY 4 HOURS AS NEEDED for itching

HYPERSENSITIVITY MEDICATIONS:
1. NURSING COMMUNICATION – If hypersensitivity or infusion reactions develop, temporarily hold the infusion and notify provider immediately. Administer emergency medications per the Treatment Algorithm for Acute Infusion Reaction (Policy HC-PAT-133-GUD, HMC C-132). Refer to algorithm for symptom monitoring and continuously assess as grade of severity may progress.
2. diphenhydrAMINE (BENADRYL) injection, 25-50 mg, intravenous, AS NEEDED x1 dose for hypersensitivity reaction
3. famotidine (PEPCID) injection, 20 mg, intravenous, AS NEEDED x1 dose for hypersensitivity reaction
4. hydrocortisone sodium succinate (SOLU-CORTEF) injection, 100 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity reaction
5. EPINEPHrine HCl (ADRENALIN) injection, 0.3 mg, intramuscular, AS NEEDED x1 dose for hypersensitivity reaction

By signing below, I represent the following:
I am responsible for the care of the patient (who is identified at the top of this form);
I hold an active, unrestricted license to practice medicine in: ○ Oregon ○ __________________________ (check box that corresponds with state where you provide care to patient and where you are currently licensed. Specify state if not Oregon);
My physician license Number is # __________________________ (MUST BE COMPLETED TO BE A VALID PRESCRIPTION); and I am acting within my scope of practice and authorized by law to order Infusion of the medication described above for the patient identified on this form.

Provider signature: __________________________ Date/Time: __________________________
Printed Name: __________________________ Phone: __________________________ Fax: __________________________
# ADULT AMBULATORY INFUSION ORDER

**Ustekinumab (STELARA) for Inflammatory Bowel Disease (Crohn's Disease and Ulcerative Colitis)**

<table>
<thead>
<tr>
<th>ACCOUNT NO.</th>
<th>MED. REC. NO.</th>
<th>NAME</th>
<th>BIRTHDATE</th>
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**Patient Identification**

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### OLC Central Intake Nurse:

Phone: 971-262-9645 (providers only) Fax: 503-346-8058

Please check the appropriate box for the patient’s preferred clinic location:

- **Beaverton**
  - OHSU Knight Cancer Institute
  - 15700 SW Greystone Court
  - Beaverton, OR 97006
  - Phone number: 971-262-9000
  - Fax number: 503-346-8058

- **NW Portland**
  - Legacy Good Samaritan campus
  - Medical Office Building 3, Suite 150
  - 1130 NW 22nd Ave.
  - Portland, OR 97210
  - Phone number: 971-262-9600
  - Fax number: 503-346-8058

- **Gresham**
  - Legacy Mount Hood campus
  - Medical Office Building 3, Suite 140
  - 24988 SE Stark
  - Gresham, OR 97030
  - Phone number: 971-262-9500
  - Fax number: 503-346-8058

- **Tualatin**
  - Legacy Meridian Park campus
  - Medical Office Building 2, Suite 140
  - 19260 SW 65th Ave.
  - Tualatin, OR 97062
  - Phone number: 971-262-9700
  - Fax number: 503-346-8058

Infusion orders located at: [www.ohsukanight.com/infusionorders](http://www.ohsukanight.com/infusionorders)

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**ONLINE 03/2022 [supersedes 08/2021]**

PO-8131